

**Memorandum**

Date AUG 31 1993

From Bryan B. Mitchell *Bryan Mitchell*
Principal Deputy Inspector General

Subject Third Party Liability Identification and Collection from Insurance Companies at the
Florida Department of Health and Rehabilitative Services (A-04-92-01020)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on September 2, 1993, of our final audit report. A copy is attached.

The purpose of our review was to determine whether the Florida Department of Health and Rehabilitative Services (DHRS) had established a system of accountability for third party liability (TPL) under the Medicaid program.

Section 1902(a)(25) of the Social Security Act, as amended, requires that State agencies ascertain the liability of third parties (including health insurers) to pay for care and services available under the Medicaid State plan.

Our review disclosed that DHRS had not sought reimbursement from Blue Cross and Blue Shield of Florida, Inc. (BCBSF) since January 1989 for 305,230 claims with potential TPL. These claims were not billed because DHRS suspended its submission of paper claims to BCBSF until an electronic billing medium could be designed and implemented by the fiscal agent. The 305,230 claims totalled \$8,539,398 (Federal share of \$4,661,089).

Our review disclosed other deficiencies that prevented the DHRS from having an acceptable system of accountability for TPL recoveries. Our recommendations address these deficiencies.

We are recommending that DHRS: (1) bill BCBSF more timely for the potential TPL claims identified in the TPL Carrier Billing File (CBF); (2) consistently bill each insurance carrier on a timely basis so that a backlog of potential TPL claims does not occur; (3) require the fiscal agent to install the rebilling function in the CBF to ensure that rebilling cycles are in compliance with the TPL subsystem documentation; (4) design and implement policies and procedures which will

Page 2 - Bruce C. Vladeck

establish controls to identify, account for, bill, collect, and report TPL resources; and (5) conduct the data exchanges with the frequency specified in its TPL action plan.

On September 21, 1992, DHRS provided a written reply to our draft report. The DHRS agreed with our recommendations for routine billing and rebilling functions and our recommendations concerning policies, procedures, and data exchanges. In addition, DHRS said it had billed BCBSF for \$1,716,216 and was continuing to pursue funds owed the Medicaid program by BCBSF.

For further information, contact:

Joseph J. Green
Regional Inspector General
for Audit Services, Region IV
(404) 331-2446

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THIRD PARTY LIABILITY IDENTIFICATION
AND COLLECTION FROM INSURANCE
COMPANIES AT THE FLORIDA
DEPARTMENT OF HEALTH AND
REHABILITATIVE SERVICES**



AUGUST 1993 A-04-92-01020



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
P. O. BOX 2047
ATLANTA, GEORGIA 30301

Common Identification No. A-04-92-01020

The Honorable Buddy MacKay
Lieutenant Governor of Florida
Acting Secretary of Florida Department of Health
and Rehabilitative Services
1317 Winewood Boulevard
Tallahassee, Florida 32399-0700

Dear Mr. MacKay:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report on our audit of Medicaid "Third Party Liability Identification and Collection from Insurance Companies at the Florida Department of Health and Rehabilitative Services." The audit covered the period July 1, 1989 through June 30, 1991. A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

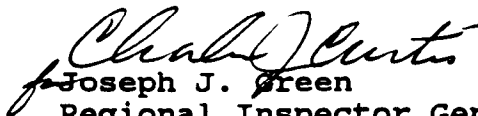
Final determination as to actions taken on all matters reported will be made by the HHS official named below. We request that you respond to each of the recommendations in this report within 30 days from the date of this letter to the HHS official named. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS reports are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5).

Page 2 - Buddy MacKay

To facilitate identification, please refer to Common Identification Number A-04-92-01020 in all correspondence relating to this report.

Sincerely yours,


Joseph J. Green
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply To HHS Action Official:

Associate Regional Administrator for Medicaid
Health Care Financing Administration
Department of Health and Human Services, Region IV
101 Marietta Towers - Room 602
Atlanta, Georgia 30323

SUMMARY

Our Audit of Third Party Liability Identification and Collection from Insurance Companies at the Florida Department of Health and Rehabilitative Services (DHRS) covered the period July 1, 1989 through June 30, 1991. The objective of our review was to determine whether the Florida DHRS had established a system of accountability for third party liability (TPL) under the Medicaid program. During this audit we examined: (1) insurance payments, (2) the validity of outstanding insurance company billings, and (3) collections from the insurance companies.

Federal laws, regulations, and guidelines require State agencies to ensure that Medicaid recipients use third party resources before seeking payment from the Medicaid program. Third party resources may include health insurance, casualty coverage resulting from an accidental injury, or payments received directly from an individual responsible for the cost of medical care provided to a Medicaid recipient.

Our review disclosed that the State agency had not sought reimbursement from Blue Cross and Blue Shield of Florida, Inc. (BCBSF), since January 1989. Claims, totalling \$8,539,398 identified and recorded in the TPL Carrier Billing File (CBF), were not billed because DHRS suspended its submission of paper claims to BCBSF until an electronic billing medium could be designed and implemented by its fiscal agent. In addition, the fiscal agent had not initiated rebilling cycle intervals to automatically rebill nonresponsive carriers and to identify the introduction of possibly erroneous and duplicate claims into the CBF.

An electronic billing medium was implemented in April 1992. The DHRS said that as of July 22, 1992 it had determined BCBSF's liability to be no more than \$1,716,216 and had billed BCBSF this amount.

Our review also showed that DHRS had not developed policies and procedures to establish controls for identifying, accounting for, billing, collecting, and reporting TPL resources under the State's Medicaid program. Finally, DHRS was not performing the types of data exchanges at the frequency addressed in its State Medicaid and TPL Action Plans.

We are recommending that DHRS: (1) bill BCBSF more timely for the potential TPL claims identified in the TPL CBF; (2) consistently bill each insurance carrier on a timely basis so that a backlog of potential TPL claims does not occur; (3) require the fiscal agent to install the rebilling function in the CBF to ensure that rebilling cycles are in compliance with the TPL subsystem documentation; (4) design and implement

policies and procedures which will establish controls to identify, account for, bill, collect, and report TPL resources; and (5) conduct the data exchanges with the frequency specified in its TPL action plan.

On September 21, 1992, DHRS provided a written reply to our draft report. The DHRS agreed with our recommendations for routine billing and rebilling functions and our recommendations concerning policies, procedures, and data exchanges. In addition, DHRS said it had billed BCBSF for \$1,716,216 and was continuing to pursue funds owed the Medicaid program by BCBSF.

The DHRS' written comments are summarized following the **Recommendations** section in each finding. Certain portions of DHRS' comments have been deleted as they no longer pertain to the final report. The remaining DHRS comments are presented in their entirety as an Appendix to this report. Where appropriate, we have responded to DHRS' comments.

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INTRODUCTION

BACKGROUND

Federal laws, regulations, and guidelines require State agencies to ensure that Medicaid recipients use third party resources to pay for their medical needs before seeking payment from the Medicaid program. Third party resources may include health insurance, casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the cost of medical care provided to a Medicaid recipient.

Section 1902(a)(25) of the Social Security Act, as amended, requires that State agencies take all reasonable measures to ascertain the liability of third parties (including health insurers) to pay for care and services available under the Medicaid State plan. The implementing regulations (title 42, Code of Federal Regulations (CFR), part 433, subpart d) require, in part, that State agencies have an action plan for pursuing TPL claims. The action plan must describe the actions and methodologies the State will follow to (1) identify third parties; (2) determine the liability of third parties; and (3) as required, either avoid payment of third party claims or recover reimbursement from third parties after Medicaid claims payment.

Title 42 CFR 433.139(d)(2) states:

"If the agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the agency must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party or benefits become available."

The regulations also require that State agencies: (1) collect health insurance information during eligibility interviews; (2) conduct data exchanges with State wage information collection agencies and worker's compensation; (3) perform trauma code edits to detect potential casualty and liability situations; and (4) establish systems to identify court-ordered medical support from absent parents.

Federal regulations define two methods for the processing of medical claims that involve TPL. The first, the cost avoidance method, requires medical providers to bill liable third parties prior to billing Medicaid. Under this approach, State agencies do not pay claims until they are reasonably satisfied that third party resources have been exhausted. The second method, called pay and chase, is required when Medicaid pays the medical bills of the recipient and then attempts to recover its payments from liable third parties. State agencies are required to use the

cost avoidance method of processing claims unless the agency received approval to use the alternative pay and chase method. Florida DHRS has been approved to use the pay and chase method.

The State of Florida has a Health Care Financing Administration (HCFA)-approved, fiscal agent operated, Medicaid Management Information System (MMIS) for the purpose of processing Medicaid claims and for other data processing activities. The MMIS includes a TPL subsystem for the further processing of TPL claims. Within the TPL subsystem is a CBF, which is comprised of three subfiles ("current", "archive", and "purged"). The CBF is used to identify claims with probable TPL and to support recovery from insurance companies for paid Medicaid claims. The CBF also generates routine billings to liable insurance companies for payment of TPL for paid Medicaid claims. As of February 15, 1992, the subfiles of the CBF listed, in aggregate, 1,032,836 potential TPL claims totalling \$29,936,121.

The reports provided by DHRS indicated that the current and purged subfiles within the CBF accounted for 305,230 BCBSF claims totalling \$8,539,398. The archive subfile contained no BCBSF claims. The purged file represented all claims added to the CBF prior to June 30, 1991; whereas, the current file included all claims added to the CBF subsequent to July 1, 1991, including all BCBSF claims created prior to July 1991 that met Florida's TPL criteria.

SCOPE

The objective of our review was to determine whether the Florida DHRS had established a system of accountability for TPL under the Medicaid program.

During this audit we examined: (1) insurance payments, (2) the validity of outstanding insurance company billings, and (3) collections from the insurance companies.

To accomplish our objectives, we reviewed the adequacy of State agency policies and procedures which established controls relative to TPL resources. We also determined whether the resources that pertained to insurance company payments were properly identified, accounted for, billed, collected, and reported. Accordingly, we reviewed:

- Medicaid laws and regulations to determine TPL program requirements;
- the HCFA's responsibilities for monitoring the State agencies' management of TPL insurance company payments;
- past and present State Auditor General reports and supporting working papers which dealt with Medicaid TPL insurance company payments;

- Florida's State Plan for Medicaid to determine if it included the required certifications to HCFA regarding the administration of the TPL program;
- Florida's Medicaid TPL Action Plan to determine the State's approach to pursuing claims against insurance companies; and
- documentation relative to TPL insurance company payments, including TPL policies, procedures, internal controls, letters from the TPL Recovery Unit, computer-generated reports, and HCFA Form 64 reports (line 9A only) for the period December 31, 1989 through June 30, 1991 to test compliance with the regulations.

Our audit was conducted in accordance with generally accepted government auditing standards except that we did not consider the internal control structure of DHRS as a whole, or of the overall Medicaid program. Instead, we reviewed only those operations that pertained to the identification of third party resources through the Medicaid eligibility verification process, the TPL subsystem within the Florida MMIS, and the TPL Recovery Unit. Accordingly, we conducted substantive tests to ascertain compliance with regulations.

For the areas tested, other than the issues discussed in the **Findings and Recommendations** section, we found no instances of material noncompliance with applicable laws and regulations. For those areas not tested, nothing came to our attention during the course of our review to indicate that the areas not tested were not in compliance with applicable laws and regulations.

Our audit was conducted at the offices of DHRS and its fiscal agent in Tallahassee, Florida. We made visits to DHRS' District II Offices, Office of Child Support Enforcement, Office of Economic Services, and the State Auditor General's Office also located in Tallahassee, Florida. Telephone contacts were made with the HCFA Regional Office in Atlanta, Georgia; BCBSF in Jacksonville, Florida; and the DHRS district offices in Pensacola and Tampa, Florida. Our field work was performed from October 1991 through June 1992 and covered the period July 1, 1989 through June 30, 1991.

FINDINGS AND RECOMMENDATIONS

INSURANCE CARRIER BILLINGS-BCBSF

The DHRS generally billed third parties, including insurance companies, on a routine basis. However, BCBSF was not billed for third party claims for more than 3 years.

In January 1989, billings to BCBSF were stopped until DHRS could prepare the billings on computerized tape. To do this, the DHRS TPL Recovery Unit initiated a Customer Service Request (CSR) #0326 on January 10, 1989 for the fiscal agent to implement a system to generate the required computerized billings for BCBSF. The fiscal agent did not act timely on the CSR. Consequently, DHRS delayed billing BCBSF for 305,230 potential TPL claims totalling \$8,539,398 for approximately 3 1/2 years.

<u>Fiscal Year</u>	<u>Medicaid Paid Claims</u>	<u>FFP Rate</u>	<u>FFP Amount</u>
1988	\$ 13,453	55.39%	\$ 7,451
1989	352,227	55.18%	194,359
1990	2,234,903	54.70%	1,222,492
1991	4,848,483	54.46%	2,640,484
1992	<u>1,090,332</u>	54.69%	<u>596,303</u>
Totals	<u>\$8,539,398</u>		<u>\$4,661,089</u>

During the 3 1/2-year period, DHRS did not reimburse the Federal government for its share of the Medicaid expenditures associated with the unbilled BCBSF claims. For the period October 1, 1987 through September 30, 1992, the FFP rates for Medicaid expenditures in Florida ranged from a low of 54.46 percent to a high of 55.39 percent.

In addition to not having a computerized billing capability, the DHRS identified other problems in the TPL subsystem. Other problems identified were the fiscal agent's failure to initiate rebilling cycle intervals for automatically rebilling nonresponsive carriers and to identify the introduction of possibly erroneous and duplicate claims into the CBF. The combination of these problems contributed to the general inefficiency of the CBF.

As a result of our disclosure of these problems to HCFA, DHRS, in April 1992, obtained a proposal from a consulting firm and a letter from the fiscal agent to initiate the billing of BCBSF claims identified in the "purged" and "current" subfiles.

Recommendations

We recommend that the DHRS:

1. bill BCBSF more timely for the potential TPL claims identified in the TPL CBF.
2. consistently bill each insurance carrier on a timely basis so that a backlog of potential TPL claims does not occur.
3. require the fiscal agent to install the rebilling function in the CBF to ensure that rebilling cycles are in compliance with the TPL subsystem documentation.

DHRS' Comments

The DHRS said that as of July 22, 1992 the maximum possible amount of Medicaid claims for which liability could potentially be sought, had been billed, and was determined to be no more than \$1,716,216 with this amount further reduced as of September 21, 1992.

The DHRS concurred with our recommendation to routinely bill all insurance carriers and stated that the carrier billing process now includes a monthly bill to all insurance carriers including BCBSF. The DHRS also concurred with our recommendation concerning the rebilling function and stated that the fiscal agent had implemented the rebill function of the CBF.

POLICIES, PROCEDURES, AND CONTROLS

The DHRS had no written policies or procedures relative to the TPL Recovery Unit. Also, the duties of personnel performing the functions of accounting, billing, and collection were inadequately segregated to provide appropriate safeguards against the loss or unauthorized use of TPL funds. Federal regulations at 42 CFR 431.17(b) require, in part, that:

"A State plan must provide that the Medicaid agency will maintain or supervise the maintenance of the records necessary for the proper and efficient operation of the plan."

In addition to being a prudent business practice, we believe this requirement extends to the organization having written operating

policies and procedures which govern the duties of all personnel assigned to the unit.

We found that personnel were governed in their duties by "desk procedures." Our review showed that the desk procedures were essentially position descriptions for the employees. In addition, personnel in the accounting section who received, accounted for, and reported TPL resources also had the ability to enter change or denial codes to the CBF for amounts billed to insurance companies. When this condition was disclosed to DHRS officials, immediate corrective action was instituted. The DHRS installed different passwords for the accounting and billing functions which provided for limited access to the use of change and denial codes. By use of the different passwords, the accounting section would be restricted to recording TPL payments to the CBF, while the billing section would still be able to delete or change TPL records.

As a result of the absence of written policies and procedures, the TPL Recovery Unit could not provide assurances that TPL resources were adequately safeguarded. We believe such assurances would be better defined if the unit had written policies and procedures which established verifiable controls over all operational aspects of the TPL Recovery Unit.

Recommendation

We recommend that the State Agency design and implement written policies and procedures for the TPL Recovery Unit which address the operating functions of each section and include the proper segregation of duties.

DHRS Comment

The DHRS concurred with this recommendation and indicated they were developing written policies and procedures that address each of the functions of the Office of Medicaid Third Party Liability.

DATA EXCHANGES

Federal regulations (42 CFR part 433.138) require States to take reasonable measures to determine the liability of third parties to pay for services furnished under the State plan. In part, the State must perform certain data exchanges in order to determine third party resources. The Florida Medicaid TPL Action Plan addressed the type and frequency of data exchanges required to comply with the Federal regulations. The TPL Action Plan was approved by HCFA on July 18, 1990.

The TPL Action Plan provided that DHRS make data exchanges with the following:

- Blue Cross and Blue Shield of Florida, Inc.
- health maintenance organizations (HMO) and preferred provider organizations (PPO)
- Department of Labor (DOL) and Highway Safety and Motor Vehicle (HSMV)
- Defense Enrollment Eligibility Reporting System (DEERS)
- State Wage and Income Collection Agencies (SWICA)

Each data exchange was to be conducted on a routinely scheduled basis. Federal guidance provided in the State Medicaid Manual (SMM) requires States to follow-up on data exchange information for the purpose of identifying liable third parties and to incorporate such information into each recipient's case file.

None of the data exchanges identified above had formal policies and procedures which specified the type, frequency, or purpose of the exchanges. There were also no formalized schedules to ensure that the data exchanges were performed in compliance with the required frequency.

Regarding the frequency of exchange, our review disclosed that DHRS conducted only 3 BCBSF data exchanges in the 2 year period covered by our audit. The TPL Action Plan required that BCBSF data exchanges be conducted every 3 months.

We also noted that DHRS did not conduct HMO or PPO data exchanges which, according to the State Plan, were to be performed on a routine basis. We found that DHRS attempted the DEERS data exchanges twice during the period covered by our audit, but for undisclosed reasons the exchanges were never successfully completed.

With regard to the DOL and HSMV data exchanges, we found that DHRS did not obtain data exchange agreements as described in the TPL Action Plan.

The State Auditor General served as the single source for processing SWICA data exchanges in Florida. We found limited documentation that demonstrated the frequency of the data exchanges. In addition, we also found that DHRS district offices did not follow-up as was required, on the matched recipients to develop potential health insurance leads. The SMM required this follow-up because every employment lead, no matter how small, could potentially be a lead for health insurance coverage.

As a result of not conducting complete and timely data exchanges DHRS may be missing opportunities for additional third party recoveries.

Recommendations

We recommend that DHRS:

1. develop written policies, procedures, and schedules which address the types, frequency, and State entity responsible for conducting the various data exchanges.
2. comply with frequency requirements for conducting data exchanges that are addressed in either the Florida State Plan or the TPL Action Plan.
3. update and obtain approval from HCFA for changes in either the Florida State Plan or the TPL Action Plan for those data exchanges or frequency of data exchanges that are not being performed in Florida.
4. comply with the Medicaid requirements (section 3903.3 of the SMM) and follow-up on all health insurance leads for those recipients that are identified in the SWICA data exchanges.

DHRS Comments

The DHRS concurred with these recommendations and indicated corrective actions were being taken.

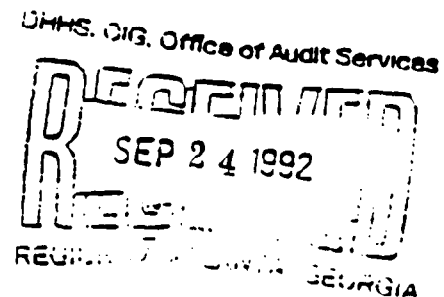
APPENDIX



STATE OF FLORIDA
DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

September 21, 1992

Mr. Emil A. Trefzger, Jr.
Regional Inspector General
for Audit Services, Region IV
P. O. Box 2047
Atlanta, Georgia 30301



Re: A-04-92-01020

Dear Mr. Trefzger:

I am writing in response to your August 25 letter regarding your Audit of Medicaid Third Party Liability Identification and Collection from Insurance Companies.

We have presented our comments on each of the recommendations in your report in the form of attachments. We also request an exit conference to discuss your findings and our comments relative to those findings. Please call Mr. George E. Strickland at 904/488-5367 to confirm a date and time for the exit conference.

Thank you for the opportunity to respond to this draft report.

Sincerely,

Robert B. Williams
Secretary

Attachments

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

Response to Draft Audit of Medicaid Third Party
Liability Identification and Collection from Insurance Companies

OIG RECOMMENDATION: Original recommendation deleted.
Recommendation now reads: Bill BCBSF more timely for the
potential TPL claims indentified in the TPL-CBF.

Office of Audit Services note -- Comments have been deleted
at this point because they pertain to material not included
in this report

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

Response to Draft Audit of Medicaid Third Party
Liability Identification and Collection from Insurance Companies

Office of Audit Services note -- Comments have been deleted
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DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

**Response to Draft Audit of Medicaid Third Party
Liability Identification and Collection from Insurance Companies**

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DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

**Response to Draft Audit of Medicaid Third Party
Liability Identification and Collection from Insurance Companies**

Office of Audit Services note -- Comments have been deleted at this point because they pertain to material not included in this report

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

Response to Draft Audit of Medicaid Third Party
Liability Identification and Collection from Insurance Companies

Office of Audit Services note -- Comments have been deleted at this point because they pertain to material not included in this report

The HRS OMTPL has completed the billing process to Blue Cross/Blue Shield of Florida and all appropriate claims with potential coverage by Blue Cross/Blue Shield have been submitted to Blue Cross/Blue Shield for processing.

5. OIG is factually inaccurate in stating that there are 305,230 TPL claims totaling \$8,539,398 as to which the state had an obligation to seek recovery from Blue Cross/Blue Shield.

OIG has claimed that HRS had an obligation to seek recovery of reimbursement from Blue Cross/Blue Shield for claims

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

**Response to Draft Audit of Medicaid Third Party
Liability Identification and Collection from Insurance Companies**

totaling \$8,539,398, of which the federal share would be \$4,683,453.

As discussed above, the data generated was treated by OIG as accounts receivables from a system not designed for, and not capable of, generating accurate accounts receivable data. Data obtained at best indicated possible coverage and therefore possible liability of Blue Cross/Blue Shield, but did not establish legal liability or probable liability. The duty to seek recovery of reimbursement does not arise until determination of liability. Furthermore, as stated above, large amounts of data were included erroneously in the CBF, and needed further evaluation by HRS prior to attempting to ascertain liability from information to be provided by Blue Cross/Blue Shield. As indicated in letters from our fiscal agent dated July 22 and 27, 1992, (attachments 3 and 4), the maximum possible amount of Medicaid claims for which liability could potentially be sought from Blue Cross/Blue Shield was determined to be no more than \$1,716,216.42, not the \$8,539,398 claimed by OIG. This amount has been further reduced since the date of the letter. HRS has submitted claims to Blue Cross/Blue Shield on tape to ascertain potential liability of Blue Cross/Blue Shield for each remaining potential claim. No determination of probable liability has yet been made for most claims.

When and to the extent liability of Blue Cross/Blue Shield has been determined by HRS for each claim, and when and to the extent TPL recovery is made from Blue Cross/Blue Shield, HRS intends to make financial adjustments on the quarterly HCFA 64 report for each such claim for which recovery has been made. HRS does not, however, intend to repay HCFA through adjustments on HCFA Form 64 for claims as to which the legal liability of Blue Cross/Blue Shield has not been determined, nor does it intend to repay HCFA for claims for which HRS has not been reimbursed.

OIG Recommendation: Make necessary arrangements to consistently bill each insurance carrier on a routine basis so that a back-log of potential TPL claims does not occur.

We concur with this recommendation. Our carrier billing process now includes a monthly bill to all insurance carriers including Blue Cross Blue Shield for all potential TPL claims.

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

**Response to Draft Audit of Medicaid Third Party
Liability Identification and Collection from Insurance Companies**

OIG Recommendation: Require the fiscal agent to install the rebilling function in the CBF to ensure the rebilling cycles are in compliance with the TPL Subsystem documentation dated April 3, 1991.

We concur with this recommendation. The fiscal agent has implemented the rebill function of the Carrier Bill File.

OIG Recommendation: Design and implement written policies, procedures and controls for the Third Party Recovery Unit which address the operating functions of each section, including the proper segregation of duties.

We concur with this recommendation. We are currently developing written policies and procedures that address each of the operating functions of the Office of Medicaid Third Party Liability. It should be noted, however, that the accounting functions of the Office of Medicaid Third Party Liability are currently directed by and operating within the guidelines of the Department's Accounting Procedures Manual (APM) and the State Comptroller's rules and regulations. Attachment 5 lists some of the accounting procedures and regulations that we currently follow in our Accounting Section. It should also be noted that personnel in the Accounting Section who received, accounted for and reported TPL resources did not have direct access to MMIS terminals nor did these employees have knowledge of computer terminal functions. At no time have these employees ever entered transactions into the MMIS.

OIG Recommendation: Develop written policies, procedures and schedules which address the types, frequencies and state entity responsible for conducting the various data exchanges.

We concur with this recommendation. In January 1991, a manual system of tracking the data match schedule was employed. Since that time we have requested data matches with outside agencies in a timely manner. However, we have no control over when and how other state agencies respond to our requests for data exchanges. Responses from other state agencies depend, to a great extent, on those agencies' own priorities and schedules. As previously indicated we are currently developing a written policy and procedure manual that will include a data match schedule and tracking system.

DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES

**Response to Draft Audit of Medicaid Third Party
Liability Identification and Collection from Insurance Companies**

OIG Recommendation: Comply with the frequency requirements for conducting data exchanges that are addressed in either the Florida State Plan or the TPL Action Plan.

We concur with this recommendation. We now have data match agreements with the Florida Department of Labor and Employment Security and the Florida Department of Highway Safety and Motor Vehicles. We believe the agreement along with our data match tracking system will enable our office to comply with the frequency requirements for data matches as addressed in the Florida State Plan or TPL Action Plan.

OIG Recommendation: Update and obtain HCFA approval for changes in either the Florida State Plan or the TPL Action Plan for those data exchanges or frequency of data exchanges that are not being performed by Florida.

We concur with this recommendation. Any inconsistencies in data exchanges or frequency of data exchanges that exist between the Florida State Plan and the TPL Action Plan will be corrected and submitted to HCFA for approval.

OIG Recommendation: Comply with the Medicaid requirements (Section 3903.3 of the State Medicaid Manual) and follow-up on all health insurance leads for those recipients that are identified in the SWICA data exchanges.

We concur with this recommendation. The fiscal agent is currently testing and we expect to implement within the next two weeks a system in the MMIS that will match the SWICA, state employees and federal employees data received from the Florida Auditor General through the FLORIDA system. The new system in the MMIS will prepare and mail questionnaires to employers concerning the availability of health insurance for their Medicaid eligible employees.

ATTACHMENT 1

Office of Audit Services note -- Comments have been deleted at this point because they pertain to material not included in this report

ATTACHMENT 2

Office of Audit Services note -- Comments have been deleted at this point because they pertain to material not included in this report

Consultec, Inc.
RECEIVED

JUL 23 1992

MEDICAID OFFICE

Florida Medicaid Fiscal Agent

2002-A1 OLD ST. AUGUSTINE ROAD
POST OFFICE BOX 5497
TALLAHASSEE, FLORIDA 32314-5497
TELEPHONE: (904) 656-7776
FAX: (904) 942-4859

Florida MMIS Project Letter Number A92202A

JUL 30 1992

July 22, 1992

RECEIVED

JUL 23 1992

MEDICAID
PROGRAM DEVELOPMENT

Mr. Art Williams, Chief
Office of Medicaid Contract Management
Department of Health and Rehabilitative Services
2002-A3 Old St. Augustine Road
Tallahassee, Florida 32301

Dear Mr. Williams:

SUBJECT: BC&S TPL Tape Billing Status/Issue - CSR 326

This is to advise you of the TPL billing status to Blue Cross and Shield. At our July 15th status meeting, we advised that the remaining claims for dates of service 1990 and older had been produced and were being mailed that day. The day before, we received the first paper copy of a remittance advice from Blue Cross and Shield for a few of the claims submitted on June 19, 1992. A review of this remittance was in process during the meeting.

The remittance identified two issue areas. First, the outpatient and physician claims showed the total billed amount at the document level was applied to each line item. This affected the outpatient claims submitted on June 19 and July 9, 1992. The issue resulted in an overstatement of the billed amount. Attached, please find a complete listing of claims billed and to be billed with corrected billed amounts.

The second issue identified that the duplicate logic applied by BC&S denies outpatient claims where the provider, recipient and date of service are identical. The claims were billed following the FMMIS TPL design of one claim per line item. BC&S processes outpatient claims at the document level. Accordingly, all tapes were submitted except the outpatient claims type with dates of service 1990 and older. Consultec is proceeding to re-format the outpatient claims and reproduce and submit the billing tape for dates of service 1990 and older.

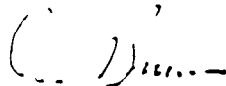
Outpatient hospital claims submitted on June 19 and July 9, 1992 are already in the BC&S processing system. BC&S advised that they would delete as many of the claims that can be intercepted and provide a listing of all claims with status. Corrective action planning by BC&S is underway but will not delay receipt and processing of all other claims.

Mr. Art Williams
July 22, 1992
Page 2

BC&S has advised that several remittance tapes have been produced and sent to the TPL unit at Winewood. We have requested specific label and shipping date information.

Please contact Tom Stockdale if further information is needed.

Sincerely,



Don Bruns
Account Manager

cc: Jeff Dishough
Tom Stockdale
Steve Halleck
John Bennett

Mr. Art Williams
July 22, 1992
Page 3

Blue Cross and Shield TPL Billing Summary

o June 19, 1992 DOS January 1, 1992 to
April 23, 1992

<u>Claims</u>	<u>Billed Amount</u>
197 Physician	\$14,785.00
11 Inpatient	19,133.00
189 Outpatient	8,046.34

TOTAL	\$41,964.34

o July 9, 1992 DOS January 1, 1991 to
April 23, 1992

<u>Claims</u>	<u>Billed Amount</u>
2,445 Physician	\$171,288.92
58 Inpatient	100,158.68
5,824 Outpatient	246,224.34
31,210 Pharmacy	737,951.18

TOTAL	\$1,255,623.12

o July 15, 1992 DOS May 1988 to
December 31, 1990

<u>Claims</u>	<u>Billed Amount</u>
777 Physician	\$ 59,511.30
1 Inpatient	1,575.42
* 2,242 Outpatient	85,316.77
13,625 Pharmacy	272,225.47

TOTAL	\$418,628.96

GRAND TOTAL \$1,716,216.42

* Not Billed

Billed as Referral on 7/24/92

Consultec, Inc.

Florida Medicaid Fiscal Agent

2002-A1 OLD ST. AUGUSTINE ROAD
POST OFFICE BOX 5497
TALLAHASSEE, FLORIDA 32314-5497
TELEPHONE: (904) 656-7776
FAX: (904) 942-4859

Florida MMIS Project Letter Number A922098

July 27, 1992

RECEIVED

JUL 28 1992

Mr. Art Williams, Chief
Office of Medicaid Contract Management
Department of Health and Rehabilitative Services
2002-A3 Old St. Augustine Road
Tallahassee, Florida 32301

MEDICAID OFFICE

Dear Mr. Williams:

SUBJECT: BC&S TPL Billing Status - CSR 326

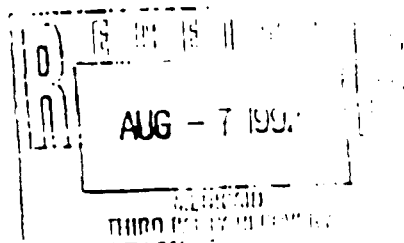
This is to advise you that the hospital outpatient claims with dates of service 1990 and older were submitted to BC&S on July 24, 1992. The claim count went from 2,242 to 1,005. This reduction is due to the change from line item billing to document billing. The billed amount is unchanged at \$85,316.77.

This section completes the tape billing submission of aged TPL claims.

Two issues remain to be resolved. First, we have not yet obtained a remittance tape to apply payments. Second, the outpatient claims submitted on July 9, 1992 require correction. We are awaiting a resolution recommendation from BC&S.

BC&S has advised that the aged claims which require archive history pulls will be denied first, then reprocessed to step over the timeliness edits.

Please contact Tom Stockdale if further information is needed.



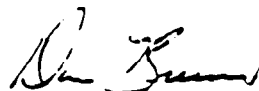
RECEIVED

JUL 28 1992

MEDICAID
PROGRAM DEVELOPMENT

Mr. Art Williams
July 27, 1992
Page 2

Sincerely,

A handwritten signature in dark ink, appearing to read "Don Bruns", with a small number "7" written above the first letter "D".

Don Bruns
Account Manager

cc: Steve Halleck -
John Bennett
Tom Stockdale
Jeff Dishongh

ATTACHMENT 5

Office of Audit Services note -- Comments have been deleted at this point because they pertain to material not included in this report